Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 03/19/02.
   b. The request was received on 06/18/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs-1500
   c. TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Medical Records
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/24/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 07/24/02. The response from the insurance carrier was received in the Division on 08/07/02. Based on 133.307 (i) the insurance carrier's response is timely. During the review of the file, it was noted that the carrier response was not in the file. In a telephone conversation with a carrier representative on 11/21/02, the representative stated that a 14-day response was faxed to the Division on 08/07/02. He faxed the complete response to the Waco Field Office on 11/21/02. The response does have a 08/07/02 fax confirmation to indicate that the original response was, indeed, faxed to the Austin Division, on 08/07/02.

4. Notice of "A letter Requesting Additional Information" is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 07/17/02
"The patient was brought in with a dislocated shoulder, which happened in the course of his employment. **The doctor took his own medical history**, which is a statement from the patient on how he was injured, and that he did not have any allergies…. We feel that our fee was fair and just, going by the TWCC fee guidelines. When payment was first denied, EOB stated documentation did not support the service billed. **The treating doctor submitted a letter explaining in more detail what he attempted to do to the patient and gave the doctor-patient time**…. We feel with the additional documentation from the treating doctor, the charge of **$74.00,** is a fair and just fee to charge for the initial office visit, and ask that we be reimbursed for our services."

2. Respondent: Letter dated 08/07/02
"The requester billed for this level of service, without providing documentation consistent with the level billed. In particular, the requestor [sic] did not demonstrate all three key components of management sufficient to warrant reimbursement.. The carrier denied reimbursement and explained, '…the documentation does not support the specific level billed as it is defined in the 1996 TWCC Medical Fee Guideline…' The 4/1/96 Medical Fee Guideline provides a [sic] the description and definition for CPT Code 99203, namely as an office visit which requires 'these three components: a detailed history; a detailed examination; medical decision making of low complexity.'."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/19/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $74.00; the amount paid is $0.00; the amount in dispute is $74.00.

3. The carrier denied the billed services by codes:
"N- Not Appropriately Documented";
"F – Fee Guideline MAR Reduction";
"TG –DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODES' VALUE PER RULE 133.301(B). A REVISED CPT CODE OR DOCUMENTATION TO THE SERVICE BILLED MAY BE SUBMITTED."
"JM – THE MEDICAL FEE GUIDELINE STATES IN THE IMPORTANCE OF PROPER CODING 'ACCURATE CODING OF SERVICES RENDERED IS ESSENTIAL FOR PROPER REIMBURSEMENT ', THE SERVICES PERFORMED ARE NOT REIMBURSABLE AS BILLED." A Retrospective Review dated 06/06/02 stated, "Reimbursement is denied for the service billed as the documentation does not support the specific level of service billed…"

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
03/19/02	99203	$74.00	$0.00	N,F,TG, JM	$74.00	MFG E/M (IV); (C) (1); (IV) (A) ; CPT descriptor	The medical documentation submitted by the provider met the key components listed in MFG, E/M Guidelines. Reimbursement in the amount of **$74.00** is recommended.
Totals		$74.00	$0.00				The Requestor **is** entitled to reimbursement in the amount of **$74.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $74.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 4th day of December 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm